STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 20,755
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals a decision by the Department for Children and Families, Office of Vermont Health Access (OVHA) denying her request for Medicaid Transportation. Petitioner is seeking mileage reimbursement for travel to a pool for self-directed aquatic physical therapy. The issues include whether the services are a medical service, and, if so, whether they are medically necessary.

FINDINGS OF FACT

1. The petitioner is a forty-five-year-old woman with multiple medical problems. According to petitioner, she is obese, has disc disease in her lower lumbar spine, lymphedema, fibromyalgia, depression, and PTSD. In addition, petitioner testified that she has mobility and balance problems.

2. Petitioner requested Medicaid Transportation reimbursement[1] to cover the mileage between her home and the YMCA. Petitioner is engaging in a self-directed program of aquatic physical therapy. Petitioner resides in a rural area in Chittenden County. Petitioner is not near a bus route for the YMCA or any of the other facilities in the county that have a pool. Petitioner chose the YMCA because they offer scholarships making her membership affordable.

3. Petitioner submitted a Request for Coverage for mileage reimbursement on or about January 8, 2007. Her request was supported by a Medical Need Form from Dr. C.S., petitioner's treating doctor, explaining that petitioner had a history of right medial meniscal tear with ongoing pain, lymphedema, and degenerative disk disease. Dr. C.S. noted that petitioner's conditions would be helped by aquatic therapy.

4. On or about February 7, 2007, petitioner received notice that her request did not meet the criteria for M108 exception process. Because transportation is a Medicaid covered service, petitioner's request needed to be determined pursuant to M755.

[1] Petitioner presently receives Medicaid Transportation reimbursement for trips to the pharmacy, her therapist, her doctor, and other medical providers.

5. On or about February 13, 2007, the Department denied petitioner's request for Medicaid Transportation noting that use of the pool for exercises was not medically necessary. Petitioner requested a fair hearing on February 13, 2007.

6. Petitioner submitted documentation from Dr. C.S. in support of her claim. According to Dr. C.S., petitioner has (1) lifelong history of obesity, (2) history of edema and lymphedema, (3) disc disease leading to ongoing back problems, (4) right knee medial meniscal tear, (5) history of varicose veins, and (6) Factor 5 Leiden in her blood creating additional risk of blood clotting. Dr. C.S. recommended that petitioner use self-directed aquatic physical therapy to address mobility and balance issues, strengthen muscles, and prevent deterioration of petitioner's orthopedic condition. The goal is to strengthen petitioner so that she can then do a land-based self-directed program.

7. Petitioner submitted documentation from D.H., licensed physical therapist and certified lymphedema therapist. D.H. provided petitioner with physical therapy and lymphedema therapy from April 2005 to August 2006. D.H. recommended aquatic therapy because (1) the pressure in the

water helps control the lymphedema and (2) petitioner has greater range of motion doing water based exercises.

8. Petitioner last received physical therapy from a physical therapist in August 2006. According to petitioner, she received both aquatic and land-based physical therapy from physical therapists in the past. Her present goal is to use the aquatic physical therapy to become strong enough to do land-based physical therapy; she wants to maximize her physical abilities. Petitioner received written instructions from her past physical therapists for aquatic exercises. Petitioner does not characterize her aquatic physical therapy as self-directed because she can call her past physical therapists with questions. There is no physical therapist at the YMCA to monitor petitioner's program.

9. S.H. is employed by OVHA and has managed the Medicaid Transportation program for the past four years. S.H. testified that Medicaid can pay mileage for transportation to medically necessary services. She distinguished between physical therapy overseen by a physical therapist and self-directed physical therapy at a pool. In the first instance, there is a medical provider overseeing a plan of care. In that case, transportation may be covered. In the second instance, there is not a medical provider and

the petitioner is not at a medical site. In that case, petitioner's program is considered an activity, not a covered service.

10. Dr. J.S.S. has been OVHA's medical director for the past 3.5 years. Dr. J.S.S. testified that petitioner has a constellation of medical conditions and that the majority of her physical complaints were related to her obesity. Based on his review of petitioner's medical history, he concluded that petitioner's self-directed program was not a medically necessary service. He testified that that he is not aware of any basis in the medical literature that would include a self-directed program as the standard of care for petitioner. He did testify that Medicaid can cover aquatic therapy when a physical therapist is on staff to supervise the program. He testified that petitioner's program could ameliorate symptoms but the relief would not be ongoing without weight loss.

ORDER

The Department's decision is affirmed.

REASONS

As part of the State Medicaid plan, the Department needs "to ensure necessary transportation for recipients to and

from providers". 42 C.F.R. § 431.53(a). To do so, the Department promulgated M755 which provides:

> Transportation
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> Transportation to and from necessary medical services is covered and available to eligible Medicaid recipients on a statewide basis.
>
> The following limitations on coverage shall apply:
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> 1. Prior authorization is required. (Exceptions may be granted in a case of a medical emergency.)
>
> 2. Transportation is not otherwise available to the Medicaid recipient.
>
> 3. Transportation is to and from necessary medical services.
>
> 4. The medical service is generally available to and used by other members of the community or locality in which the recipient is located. A recipient's freedom of access to health care does not require Medicaid to cover transportation at unusual or exceptional cost in order to meet a recipient's personal choice of provider.
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> 5. Payment is made for the least expensive means of transportation and suitable to the medical needs of the recipient.
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> 6. Reimbursement for the service is limited to enrolled transportation providers.
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> 7. Reimbursement is subject to utilization control and review in accordance with the requirements of Title XIX.
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> 8. Any Medicaid-eligible recipient who believes that his or her request for transportation has been improperly denied may request a fair

> hearing. For an explanation, see the "Fair Hearing Rules" listed in the Table of Contents.

The Department has developed Medicaid Transportation Procedures; these procedures reference medical necessity as those services recognized by Medicaid. In doing so, the procedures include illustrative lists of normal medical providers (various medical professionals) and normal medical sites (medical provider offices, rehab services, pharmacies). Medicaid Transportation Procedures 3.3.4.2. Medicaid can cover the cost of physical therapists. If petitioner had been approved for physical therapy with a physical therapist, there is no question that she would be eligible for Medicaid Transportation.

Petitioner is pursuing a self-directed program. Her program is neither supervised nor monitored by a physical therapist. She is not pursuing her program at a rehabilitation center. Petitioner's case raises questions because she is not asking for reimbursement to a site (YMCA) that would be considered a "normal medical site" and because she is not asking for reimbursement to a site at which she would receive services from a "normal medical provider". As such, the regulations appear to preclude coverage.

Petitioner argues that she is following doctor's orders and using a program that both ameliorates her symptoms and prevents further deterioration. Petitioner raises the issue whether her self-directed program meets the requirements for prior approval for a medically necessary service.

Prior authorization requirements are found in M106. The key issue is whether a service is medically needed. M106 refers to M107 for a definition of "medically necessary". M107 states:

> "Medically necessary" means health care services, including diagnostic testing, preventive services, and aftercare, in terms of type, amount, frequency, level, setting and duration to the beneficiary's diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters. . .and,
>
> 1. help restore or maintain the beneficiary's health; or
>
> 2. prevent deterioration or palliate the beneficiary's condition, or
>
> 3. prevent the reasonably likely onset of a health problem or detect an incipient problem.

The regulation first references "health care services". The problem is that petitioner's self-directed aquatic program is not a medical service but an activity. Her program is akin to self-directed exercises or participation in self-help groups (AA, weight watchers, etc.). Although these activities may lead to medical benefits for

participants, these activities do not constitute medical services.

The Department's determination to deny Medicaid Transportation reimbursement is reasonable based on the evidence and regulations. As a result, transportation to the YMCA is not covered by Medicaid Transportation, and the Department's decision is affirmed. 3 V.S.A. § 3091(d), Fair Hearing Rule No. 17.

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